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The concept of Folie à deux in adolescents

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The following paper provides an introduction and selective review of the literature relating to the concept of Folie à deux or shared psychosis in adolescents. An example from our own clinical practice is examined whilst implications for professionals working with young people who report shared psychotic symptoms are discussed.

The concept

Folie à deux (also referred to as shared psychosis or double insanity) was first described by Lasague and Falret in 1877. They defined the phenomena as the transference of psychotic symptoms from a 'primary' affected individual to one or more 'secondary' individuals (Wehmeier, Barth & Remschmidt, 2003). To date one of the most high profile documented cases involves the story of sisters Sabina and Ursula Eriksson (which became the subject of a BBC documentary; "Madness in the fast lane"; BBC, 2008). Not only were both sisters filmed running out onto the M6 motorway but Sabina later went on to murder Glenn Hollinshead the following day. Both the prosecution and defense claimed that Sabina was insane at the time of the killing (experiencing paranoid symptoms and auditory 'voice' experiences), although she was sane at the time of her trial. The defense claimed that Sabina was the "secondary" sufferer of Folie à deux, influenced by the presence or perceived presence of her twin sister – the "primary" sufferer.

At the present time, Folie à deux is listed in both diagnostic manuals: ICD-10 (as Induced Delusional Disorder, F.24; WHO, 2007) and DSM-IV-TR (as Shared Psychotic Disorder, 297.3; American Psychiatric Association, 2000). Table 1 outlines the current diagnostic criteria.

Table 1. Diagnostic criteria for ‘Induced Delusional Disorder’ and ‘Shared Psychotic Disorder’

ICD-10 Diagnostic Criteria for F.24 Induced Delusional Disorder

1. *Two people share the same delusion or delusional system and support one another in this belief.*
2. *They have an unusually close relationship.*
3. *Temporal or contextual evidence exists that indicates the delusion was induced in the passive member by contact with the active partner.*

DSM-IV-TR Diagnostic Criteria for 297.3 Shared Psychotic Disorder

1. *A delusion develops in an individual in the context of a close relationship with another person or persons, who have an already established delusion.*
2. *The delusion is similar in content to that of the person who already has an established delusion.*
3. *The disturbance is not better accounted for by another psychotic disorder (e.g., schizophrenia) or a mood disorder with psychotic features and is not due to the direct physiological effects of a substance (e.g., drug abuse, medication) or a general medical condition.*

In terms of the mechanisms by which induction of psychotic symptoms in Folie à deux take place, genetic factors, co-morbid mental health conditions, social isolation and abnormal personality traits have been perceived to be relevant and may predispose individuals to the condition (Silveira & Seeman, 1995). It appears that disturbed and dysfunctional interpersonal relationships are the most significant risk factors, based upon the observation that symptoms disappear quickly when affected individuals are eventually separated (Wehmeier et al., 2003). A recent review of the literature indicates that those involved are usually within the nuclear family (parent-offspring, partner-partner or sibling-sibling) although a small handful of cases have been reported between genetically unrelated individuals such as close friends (Arnone, Patel & Tan, 2006; Silveira & Seeman, 1995). As for interventions that have been utilised to treat suspected cases, anti-psychotic and anti-depressant medication is well documented in combination with a 'physical' separation of the individuals in question (Arnone et al., 2006; Friedmann, Ekeowa-Anderson, & Taylor, 2006). Psychotherapy has been utilised in a handful of cases but usually for 'secondary' individuals whose symptoms may be less developed and enduring (Arnone et al., 2006).

Despite the existence of these diagnostic criteria, their validity has been challenged based upon the limited understanding of the mechanisms involved, an inability (and lack of attempt) to obtain an accurate estimate of the conditions prevalence as well as the absence of an evidence base regarding treatment. Maybe more alarmingly, a closer examination of documented case studies within the published literature suggests few of these would actually meet these diagnostic definitions (Wehmeier et al., 2003).

Folie à deux in adolescents

An initial review of the literature indicates that the concept in adolescents is not well documented. This however may be a genuine reflection of the conditions incidence in this age group since the most recent review of the concept indicates that ‘primary’ and ‘secondary’ sufferers are usually adults (Arnone et al., 2006). This review, which included over forty case studies, calculated that the mean age of those affected was between 46-53 years of age (Arnone et al., 2006).

In the handful of adolescent cases that have been documented (Chapman & Silva, 1998; Dodig-Curkovic et al., 2008) there appears to be a usual pattern of parent-offspring or sibling-sibling induction. Social isolation is once again heavily present and a mentally ‘healthy’ adult who is in a position to offset the effect of the ‘primary’ individual is often absent. In these instances children seem to adopt the psychotic symptoms in order to stabilize or improve the relationship between themselves and their parents/family members (Wehmeier et al., 2003).

One example we wish to describe from our own clinical practice is that of a fifteen year old female, WD¹, initially referred to our Early Intervention in Psychosis (EIP) service because of a significant decline in school attendance and the reporting of auditory hallucinations. Upon assessment it became clear that her friends were also accessing our service (based upon information previously obtained during monthly peer supervision) because of the close similarity of her reported symptoms but also because she personally stated that she had friends who also “heard voices”. In terms of her symptoms, WD described hearing a male voice named “Sam” which she stated was her spirit guide. The name Sam was apparently discovered by her friends who had asked their own spirit guides to find out more about WDs

¹ Initials and names have been altered to protect the young persons identity

voice. WD reported mixed feelings in relation to Sam as he provided positive advice at times but could also make derogatory remarks about her and other family members. She also reported that when Sam was derogatory she struggled to interact and avoided contact with other people. The fact that WD could doubt/challenge the existence of Sam during our assessment and the varied frequency of her symptoms meant that she was not diagnosed as being psychotic but at high risk of developing the condition over the short term (a possible prodromal stage).

The example described here bears some of the risk factors of Folie à deux with WD reporting social isolation because of anxious school avoidance but having one or two intense, influential, yet dysfunctional social relationships. What is interesting however is that WDs story is subtly different to accounts previously described in the adolescent literature, due to the presentation of sub threshold positive psychotic symptoms which were shared with one or two non-family members (i.e. peers). Upon reflection this is not an uncommon observation within our own clinical practice.

When WDs condition was reviewed six months later, she no longer reported Sam's presence. It had transpired that she had made significant improvements in managing her anxiety, attending school and overall social functioning. She had in fact moved away from her previous group of friends (the potential 'primaries') and joined another peer group at school (therefore achieving separation, which may have been a significant factor in her recovery). In the future it was formulated that a potential decline in WDs social functioning combined with her suggestible personality type, could lead to a re-emergence of her symptoms.

Although the case of WD is just one example from our practice, our overall clinical experience has lead us to question; Why do a high proportion of adolescents referred to our service report shared psychotic like symptoms? For one, our observations may simply reflect the fact that a high proportion of adolescents within the ‘normal’ population report unusual psychotic like experiences (McGorry et al., 1995). Indeed certain characteristics typical of normal adolescent development such as conflicted family relationships, grandiosity, egocentricity and magical ideation bear a close resemblance to psychotic like features (Harrop & Trower, 2001).

However it is more plausible that teenagers report and experience shared symptoms as they strive to gain autonomy from their parents and start to relate and idolise peers to replace this lost attachment. Teenagers therefore seek ‘New Gods’ (Harrop & Trower, 2001) and forge relationships with others by any means possible. An intriguing finding by Harrop and Trower is that ‘normal’ teenagers who report a high number of psychotic like symptoms are deemed to be the most autonomous from their parents. The importance and influence of peer groups during adolescence is therefore huge and it is no wonder that a qualitative study of clinicians working with young people who experience psychotic like symptoms highlighted this point, with one professional stating:

“I can see a big difference in working with the under 18’s to the adults in terms of how important peers are and sort of the influence of peer groups and you know we have some recent examples of people becoming caught up in other peoples stories about hearing voices and it all kind of gets mixed up” (Welsh & Tiffin, 2012).

The influence of peers alongside normal maturational and developmental processes adds to the complexity of working with individuals experiencing psychotic like symptoms especially as clinicians try to untangle genuine experiences from those that are potentially fabricated or induced by a young persons peer group.

Clinical implications and future research

We therefore believe that regular supervision and training that promotes an understanding of child development and adolescent cognitive processes will be beneficial for professionals who may come into contact with young people who experience/report shared psychotic like experiences on a regular basis. In the absence of any official evidence based treatment criteria, more must be done to develop and evaluate the use of psychological interventions in this patient group, given the potential harm associated with anti-psychotic medication use in young people with psychotic symptoms (Bentall & Morrison, 2002). This view is supported by Mentjox, van Houten and Kooiman (1993) who state that interventions aimed at separation in psychological, not just physical terms, are more likely to be successful and longstanding. Psychological therapy encourages the development of healthy coping strategies which can adopt the stabilizing role previously played by the induced symptoms. A recent study has also shown that child and adolescent mental health professionals appear to prefer the use of more benign interventions (such as psycho-education and psychological ‘talking’ therapies) when treating sub-threshold psychotic like symptoms in the absence of evidence based guidelines (Welsh, Mediavilla & Tiffin, 2011).

Finally, this paper also highlights the need for a more robust and accurate case note audit of how many young people within mental health services present with shared psychotic like symptoms (as well as a more reliable estimate of how many of these would actually meet

official diagnostic criteria) in order to allocate future resources for research and training. Within our own EIP service, informal estimates suggest that 20% of assessments (from approximately 85 conducted within a 12-month period) bore a strong resemblance to Folie à deux (although given the methods used to obtain this figure it is unlikely that all of these cases would have met current diagnostic criteria). It is possible that current diagnostic criteria are inadequate/invalid in characterising the concept of Folie à deux in adolescents because of the observed peer-peer pattern of induction as well as the sub threshold nature of symptoms which may in fact be the result of ‘normal’ maturational processes. These observations and assumptions however require a thorough investigation.

Summary

Although the existing literature indicates that Folie à deux or shared psychosis is an infrequent clinical occurrence, many young people presenting to our own clinical service have demonstrated various symptoms and risk factors associated with the condition. Due to the observed frequency and complexity of working with adolescents who report shared (sub-threshold) symptoms, we recommend that clinicians working within this area undergo regular supervision and training. Obtaining a ‘true’ estimate of the conditions prevalence and a better understanding of the mechanisms behind shared psychotic like symptoms will hopefully lead to the development of evidence based psychological interventions for Folie à deux.

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